(b) CROP AND LIVESTOCK INDEMNITY PAYMENTS.—The Secretary shall use the amount made available under this section to establish a program to provide crop or livestock indemnity payments to agricultural producers for the purpose of remedying losses caused by damaging weather or related condition resulting from a natural or major disaster or emergency over a prolonged period.

SEC. ___08. FLOODED LAND RESERVE PROGRAM.

For an additional amount to carry out a flooded land reserve program, there is appropriated, out of any money in the Treasury not otherwise appropriated, $300,000,000.

SEC. ___09. FARM SERVICE AGENCY.

For an additional amount for the Farm Service Agency, to be used at the discretion of the Secretary, for salaries and expenses of the Farm Service Agency, there is appropriated, out of any money in the Treasury not otherwise appropriated, $50,000,000.

SEC. ___10. OILSEED PURCHASES AND DONATIONS.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall use not less than $750,000,000 of funds of the Commodity Credit Corporation for the purchase and distribution of oilseeds, vegetable oil, and oilseed meal under applicable food aid authorities, including—

(1) section 416(b) of the Agricultural Act of 1949 (7 U.S.C. 1431(b));

(2) the Food for Progress Act of 1985 (7 U.S.C. 1736o); and

(3) the Agricultural Trade Development and Assistance Act of 1954 (7 U.S.C. 1691 et seq.).

(b) LEAST DEVELOPED COUNTRIES.—Not less than 75 percent of the commodities distributed pursuant to this section shall be made available to least developed countries, as determined by the Secretary.

(c) LOCAL CURRENCIES.—To the maximum extent practicable, local currencies generated from the sale of commodities under this section shall be used for development purposes that foster United States agricultural exports.

SEC. ___11. UPLAND COTTON PRICE COMPETITIVENESS.

(a) IN GENERAL.—Section 136(a) of the Agricultural Market Transition Act (7 U.S.C. 7236(a)) is amended—

(1) in paragraph (1), by inserting ''(in the case of each of the 1999–2000 and 2000–2001 marketing years for upland cotton, at the option of the recipient)'' after ''or cash payments'';

(2) by inserting ''(or, in the case of each of the 1999–2000 and 2000–2001 marketing years for upland cotton, 1.25 cents per pound)'' after ''3 cents per pound'' each place it appears;

(3) in paragraph (3), by striking subparagraph (A) and inserting the following:

''(A) REDEMPTION, MARKETING, OR EXCHANGE.—

''(i) IN GENERAL.—The Secretary shall establish procedures for redeeming marketing certificates for cash or marketing or exchange of the certificates for—

''(I) except as provided in subclause (II), agricultural commodities owned by the Commodity Credit Corporation in such manner, and at such price levels, as the Secretary determines will best effectuate the purposes of cotton user marketing certificates; or

''(II) in the case of each of the 1999–2000 and 2000–2001 marketing years for upland cotton, agricultural commodities owned by the Commodity Credit Corporation or pledged to the Commodity Credit Corporation as collateral for a loan in such manner, and at such price levels, as the Secretary determines will best effectuate the purposes of cotton user marketing certificates, including enhancing the competitiveness and marketability of United States cotton.

''(ii) PRICE RESTRICTIONS.—Any price restrictions that would otherwise apply to the disposition of agricultural commodities by the Commodity Credit Corporation shall not apply to the redemption of certificates under this subparagraph.''; and

(4) in paragraph (4), by inserting before the period at the end the following: '', except that this paragraph shall not apply to each of fiscal years 2000 and 2001''.

(b) ENSURING THE AVAILABILITY OF UPLAND COTTON.—Section 136(b) of the Agricultural Market Transition Act (7 U.S.C. 7236(b)) is amended—

(1) in paragraph (1), by striking ''The'' and inserting ''Except as provided in paragraph (7), the''; and

(2) by adding at the end the following:

''(7) 1999–2000 AND 2000–2001 MARKETING YEARS.—

''(A) IN GENERAL.—In the case of each of the 1999–2000 and 2000–2001 marketing years for upland cotton, the President shall carry out an import quota program as provided in this paragraph.

''(B) PROGRAM REQUIREMENTS.—Except as provided in subparagraph (C), whenever the Secretary determines and announces that for any consecutive 4-week period, the Friday through Thursday average price quotation for the lowest-priced United States growth, as quoted for Middling (M) 1$\frac{3}{32}$-inch cotton, delivered C.I.F. Northern Europe, adjusted for the value of any certificate issued under subsection (a), exceeds the Northern Europe price by more than 1.25 cents per pound, there shall immediately be in effect a special import quota.

''(C) TIGHT DOMESTIC SUPPLY.—During any month for which the Secretary estimates the season-ending United States upland cotton stocks-to-use ratio, as determined under subparagraph (D), to be below 16 percent, the Secretary, in making the determination under subparagraph (B), shall not adjust the Friday through Thursday average price quotation for the lowest-priced United States growth, as quoted for Middling (M) 1$\frac{3}{32}$-inch cotton, delivered C.I.F. Northern Europe, for the value of any certificates issued under subsection (a).

''(D) SEASON-ENDING UNITED STATES STOCKS-TO-USE RATIO.—For the purposes of making estimates under subparagraph (C), the Secretary shall, on a monthly basis, estimate and report the season-ending United States upland cotton stocks-to-use ratio, excluding projected raw cotton imports but including the quantity of raw cotton that has been imported into the United States during the marketing year.

''(E) LIMITATION.—The quantity of cotton entered into the United States during any marketing year described in subparagraph (A) under the special import quota established under this paragraph may not exceed the equivalent of 5 weeks' consumption of upland cotton by domestic mills at the seasonally adjusted average rate of the 3 months immediately preceding the first special import quota established in any marketing year.''.

(c) REMOVAL OF SUSPENSION OF MARKETING CERTIFICATE AUTHORITY.—Section 171(b)(1)(G) of the Agricultural Market Transition Act (7 U.S.C. 7301(b)(1)(G)) is amended by inserting before the period at the end the following: '', except that this subparagraph shall not apply to each of the 1999–2000 and 2000–2001 marketing years for upland cotton''.

(d) REDEMPTION OF MARKETING CERTIFICATES.—Section 115 of the Agricultural Act of 1949 (7 U.S.C. 1445k) is amended—

(1) in subsection (a)—

(A) by striking ''rice (other than negotiable marketing certificates for upland cotton or rice)'' and inserting ''rice, including the issuance of negotiable marketing certificates for upland cotton or rice'';

(B) in paragraph (1), by striking ''and'' at the end;

(C) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following:

''(3) redeem negotiable marketing certificates for cash under such terms and conditions as are established by the Secretary.''; and

(2) in the second sentence of subsection (c), by striking ''export enhancement program or the marketing promotion program established under the Agricultural Trade Act of 1978'' and inserting ''market access program or the export enhancement program established under sections 203 and 301 of the Agricultural Trade Act of 1978 (7 U.S.C. 5623, 5651)''.

SEC. ___12. EMERGENCY CONSERVATION PROGRAM.

For an additional amount to carry out the emergency conservation program authorized under sections 401, 402, and 404 of the Agricultural Credit Act of 1978 (16 U.S.C. 2201, 2202, 2204) to provide cost-sharing assistance to eligible persons—

(1) to control weeds and establish cover crops in counties in which at least 20 percent of available cropland is prevented from being planted to an agricultural commodity as the result of damaging weather or related condition; and

(2) to reestablish permanent vegetative cover on acreage on which such cover is absent as the result of prolonged flooding;

as determined by the Secretary, there is appropriated, out of any money in the Treasury not otherwise appropriated, $30,000,000.

SEC. ___13. EMERGENCY REQUIREMENT.

(a) IN GENERAL.—The entire amount necessary to carry out this title and the amendments made by this title shall be available only to the extent that an official budget request for the entire amount, that includes designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900 et seq.) is transmitted by the President to Congress.

(b) DESIGNATION.—The entire amount is designated by Congress as an emergency requirement pursuant to section 251(b)(2)(A) of that Act (2 U.S.C. 901(b)(2)(A)).

SEC. ___14. AVAILABILITY.

The amount necessary to carry out this title and the amendments made by this title shall be available for fiscal years 1999 and 2000.

PATIENTS' BILL OF RIGHTS ACT OF 1999

BINGAMAN (AND OTHERS) AMENDMENT NO. 1245

Mr. KENNEDY (for Mr. BINGAMAN (for himself, Mr. HARKIN, Mr. DODD, Mrs. MURRAY, Mr. REID, Mr. EDWARDS, Mrs. BOXER, Mr. DURBIN, Mr. GRAHAM, Mr. KENNEDY, Mr. DASCHLE, Mr. FEINGOLD, Mr. ROCKEFELLER, Mrs. FEINSTEIN, Mr. REED, and Mr. KERRY)) proposed an amendment to amendment No. 1243 proposed by Ms. COLLINS to the bill, S. 1344, supra; as follows:

At the appropriate place, insert the following:

SEC. ___. ACCESS TO SPECIALTY CARE.

(a) SPECIALTY CARE FOR COVERED SERVICES.—

(1) IN GENERAL.—If—

(A) an individual is a participant or beneficiary under a group health plan or an enrollee under group health insurance coverage offered by a health insurance issuer,

(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(C) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(2) SPECIALIST DEFINED.—For purposes of this subsection, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(3) CARE UNDER REFERRAL.—A group health plan, or health insurance issuer in connection with group health insurance coverage, may require that the care provided to an individual pursuant to such referral under paragraph (1) be—

(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(5) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(b) SPECIALISTS AS CARE COORDINATORS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care. If such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(2) TREATMENT AS CARE COORDINATOR.—Such specialist shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan (referred to in subsection (a)(3)(A)).

(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''special condition'' means a condition or disease that—

(A) is life-threatening, degenerative, or disabling, and

(B) requires specialized medical care over a prolonged period of time.

(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(c) STANDING REFERRALS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer in connection with group health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist.

(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(d) APPLICATION OF SECTION.—This section shall supersede the provisions of section 104.

(e) REVIEW.—Failure to meet the requirements of this section shall constitute an appealable decision under section 132(a)(2).

(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any provision of this subchapter, the group health plan shall not be liable for such violation unless the plan caused such violation.

(g) NONAPPLICATION OF CERTAIN PROVISION.—Only for purposes of applying the requirements of this section under section 714 of the Employee Retirement Income Security Act of 1974 (as added by section 301 of this Act), sections 2707 and 2753 of the Public Health Service Act (as added by sections 201 and 202 of this Act), and section 9813 of the Internal Revenue Code of 1986 (as added by section 401 of this Act)—

(1) section 2721(b)(2) of the Public Health Service Act and section 9831(a)(1) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section; and

(2) with respect to limited scope dental benefits, subparagraph (A) of section 733(c)(2) of the Employee Retirement Income Security Act of 1974, subparagraph (A) of section 2791(c)(2) of the Public Health Service Act, and subparagraph (A) of section 9832(c)(2) of the Internal Revenue Code of 1986 shall not apply to the provisions of this section.

(h) NO IMPACT ON SOCIAL SECURITY TRUST FUND.—

(1) IN GENERAL.—Nothing in this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(2) TRANSFERS.—

(A) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(B) TRANSFER OF FUNDS.—If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such section.

(i) LIMITATION ON ACTIONS.—

(1) IN GENERAL.—Except as provided for in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 of the Employee Retirement Income Security Act of 1974 by a participant or beneficiary seeking relief based on the application of any provision in this section.

(2) PERMISSIBLE ACTIONS.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) of section 502 of the Employee Retirement Income Security Act of 1974 by a participant or beneficiary seeking relief based on the application of this section to the individual circumstances of that participant or beneficiary; except that—

(A) such an action may not be brought or maintained as a class action; and

(B) in such an action relief may only provide for the provision of (or payment for) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney's fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.

(j) EFFECTIVE DATE.—The provisions of this section shall apply to group health plans for plan years beginning after, and to health insurance issuers for coverage offered or sold after, October 1, 2000.

(k) INFORMATION REQUIREMENTS.—

(1) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 180 days after the date of the enactment of this Act.

(l) MODIFICATION TO FOREIGN TAX CREDIT CARRYBACK AND CARRYOVER PERIODS.—

(1) IN GENERAL.—Section 904(c) of the Internal Revenue Code of 1986 (relating to limitation on credit) is amended—

(A) by striking ''in the second preceding taxable year,'', and

(B) by striking ''or fifth'' and inserting ''fifth, sixth, or seventh''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to credits arising in taxable years beginning after December 31, 2001.

MCCAIN AMENDMENTS NOS. 1246–1249

(Ordered to lie on the table.)

Mr. MCCAIN submitted four amendments intended to be proposed by him to the bill, S. 1344, supra; as follows:

AMENDMENT NO. 1246

At the appropriate place, insert the following:

SEC. ___. PERMISSIBILITY OF CIVIL ACTIONS.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following subsection:

''(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action under State law to recover damages resulting from personal injury or for wrongful death against any person—

''(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan; or

''(ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

''(B) REQUIREMENTS.—A participant or beneficiary may only commence a civil action under subparagraph (A) if the participant or beneficiary has participated in and completed an external appeal with respect to the decision involved.

''(C) DAMAGES.—In a civil action permitted under subparagraph (B), the participant or beneficiary may only seek compensatory damages.

''(D) LIMITATION ON DAMAGES.—A group health plan shall not be liable for any noneconomic damages in the case of a cause of action brought under subparagraph (A) in excess of $250,000.

''(2) EXCEPTION FOR EMPLOYERS AND MEDICAL PROVIDERS.—

''(A) EMPLOYERS.—

''(i) IN GENERAL.—Subject to clause (ii), paragraph (1) does not authorize—

''(I) any cause of action against an employer maintaining the group health plan or against an employee of such an employer acting within the scope of employment, or

''(II) a right of recovery or indemnity by a person against an employer (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

''(ii) SPECIAL RULE.—Clause (i) shall not preclude any cause of action described in paragraph (1) against an employer (or against an employee of such an employer acting within the scope of employment) if—

''(I) such action is based on the employer's (or employee's) exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(II) the exercise by such employer (or employee of such authority) resulted in personal injury or wrongful death.

''(B) MEDICAL PROVIDERS.—Paragraph (1) does not authorize any cause of action against a health care provider for failure to provide a health care item or service where such provider acted in good faith in relying upon a determination by the group health plan involved to deny such item or service and such denial results in injury or death.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting a cause of action under State law for the failure to provide an item or service which is specifically excluded under the group health plan involved.

''(4) DEFINITION.—In this subsection, the term 'medical provider' means a physician or other health care professional providing health care services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts and omissions occurring on or after the date of the enactment of this Act from which a cause of action arises.

AMENDMENT NO. 1247

At the appropriate place, insert the following:

SEC. ___. COVERAGE OF MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

(a) GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.), as amended by section 201, is further amended by adding at the end the following:

''SEC. 2708. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.''.

(B) CONFORMING AMENDMENT.—Section 2723(c) of the Public Health Service Act (42 U.S.C. 300gg–23(c)) is amended by striking ''section 2704'' and inserting ''sections 2704 and 2708''.

(2) ERISA AMENDMENTS.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 301, is further amended by adding at the end the following:

''SEC. 715. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease,

or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.''.

(B) CONFORMING AMENDMENTS.—

(i) Section 731(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191(c)) is amended by striking ''section 711'' and inserting ''sections 711 and 715''.

(ii) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 715''.

(iii) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 401, is further amended—

(A) in the table of sections, by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''; and

(B) by inserting after section 9812 the following:

''SEC. 9814. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.''.

(b) INDIVIDUAL HEALTH INSURANCE.—

(1) IN GENERAL.—Part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-41 et seq.), as amended by section 202, is further amended by inserting after section 2753 the following new section:

''SEC. 2754. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.''.

(2) CONFORMING AMENDMENT.—Section 2762(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–62(b)(2)) is amended by striking ''section 2751'' and inserting ''sections 2751 and 2754''.

(c) EFFECTIVE DATES.—

(1) GROUP MARKET.—The amendments made by subsection (a) shall apply with respect to group health plans for plan years beginning on or after January 1, 2000.

(2) INDIVIDUAL MARKET.—The amendment made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

(d) COORDINATED REGULATIONS.—Section 104(1) of Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, and chapter 100 of the Internal Revenue Code of 1986''.

● Mr. McCAIN. Mr. President, I am offering an amendment which would help one of our most vulnerable populations, our children, by addressing the growing problem of HMOs denying insurance coverage of reconstructive surgery for kids suffering from physical defects and deformities. This amendment would require medical plans to cover the medical procedures to reconstruct a child's appearance if they are born with abnormal structures of the body, including a cleft lip or palate.

Today, approximately seven percent of American children are born with pediatric deformities and congenital defects such as cleft lip, cleft palate, missing external limbs, such as ears, and other facial deformities. Unfortunately, it has become commonplace for insurance companies to label these medical procedures as cosmetic surgery and deny coverage to help these children eradicate or reduce deformities and acquire a normal appearance.

In fact, a recent survey of the American Society of Plastic and Reconstructive Surgeons indicated that over half of the plastic surgeons questioned have had a pediatric patient in the last two years who has been denied, or experienced tremendous difficulty in obtaining, insurance coverage for there surgical procedures.

I find it disgraceful that many insurance companies claim that reconstructive procedures are not medically necessary and are therefor cosmetic. These companies claim that medical services restoring some semblance of a normal appearance are superfluous and performed merely for vanity or cosmetic purposes. Many of my colleagues may be wondering how such a ludicrous and cruel practice can occur when it seems obvious that these procedures are clearly reconstructive and not cosmetic in nature. While an insurance plan may attempt to claim that helping a child born without ears or with a cleft so severe it extends to her hairline is superfluous surgery, I adamantly disagree and am committed to stopping the abhorrent practice.

The medical and developmental complications which arise from many of these conditions are tremendous. Speech impediments, hearing difficulties and dental problems are a few of

the physical side effects which may result from a child's physical deformity. In addition, the effect a child's deformities may have on their personal development, confidence, self-esteem and their future aspirations and achievements are often very far reaching.

A healthy self image is vitally important to develop self esteem and confidence. How a person sees themselves, and how others see them, determines how the person feels about himself and defines whether he has the strength to resist unfortunate obstacles, including the taunting of peer and disengagement from school activities. As parents, we want our children to be armed with a healthy sense of self esteem and confidence. The best way to guarantee that happens is to help them develop a strong and health self image. While this is critical, we must be pragmatic and recognize that we live in a society which places a high value on physical beauty and often unfairly uses it as a measurement of a person's worth, ability or potential in society. While this is wrong and we must work together to instill self-worth in our children, it is unrealistic to not recognize the importance which is place on physical appearances in our world and the unfair obstacles which children born with deformities face if they are not provided access medical services which help them attain a normal physical appearance.

Some of my colleagues may know that my daughter Bridget, whom Cindy and I adopted from Mother Theresa's orphanage in Bangladesh, was born with a severe cleft. We are fortunate to have had the means and opportunities to provide the expert medical care necessary to help Bridget physically and emotionally. However, we, too, encountered numerous obstacles and denials by our insurance providers who did not believe that Bridget's medical treatment was necessary. Fortunately, Cindy and I were able to provide Bridget access to the reconstructive services she needs, despite denials by our health plan. Unfortunately, most hard working American families are not so fortunate. This is not right and it is why I am offering this important amendment to assist all American children.

I want to stress that this is not a new mandate which could cause health care premiums to escalate. What I am proposing simply prohibits plans from frivolously ruling that substantial, medically needed reconstructive surgery for children to obtain a relatively normal appearance is cosmetic, or denying reconstructive coverage which American families have purchases. I urge each of my colleagues to work with me on behalf of our children and ensure that they are afforded an opportunity to realize their full potential.●

AMENDMENT NO. 1248

At the appropriate place, insert the following:

SEC. ___. COVERAGE OF MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

(a) GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.), as amended by section 203(a), is further amended by adding at the end the following:

"SEC. 2708. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.''.

(B) CONFORMING AMENDMENT.—Section 2723(c) of the Public Health Service Act (42 U.S.C. 300gg–23(c)) is amended by striking ''section 2704'' and inserting ''sections 2704 and 2708''.

(2) ERISA AMENDMENTS.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 111 and 202(a), is further amended by adding at the end the following:

"SEC. 716. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.''.

(B) CONFORMING AMENDMENTS.—

(i) Section 731(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191(c)) is amended by striking ''section 711'' and inserting ''sections 711 and 716''.

(ii) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 716''.

(iii) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 715 the following new item:

''Sec. 716. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 204, is further amended—

(A) in the table of sections, by inserting after the item relating to section 9814 the following new item:

''Sec. 9815. Standards relating to benefits for minor child's congenital or developmental deformity or disorder.''; and

(B) by inserting after section 9814 the following:

"SEC. 9815. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment

which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.''.

(b) INDIVIDUAL HEALTH INSURANCE.—

(1) IN GENERAL.—Part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-41 et seq.), as amended by section 203(b), is further amended by inserting after section 2753 the following new section:

''SEC. 2754. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD'S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

''(a) REQUIREMENTS FOR RECONSTRUCTIVE SURGERY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child shall include any individual through 21 years of age.

''(2) REQUIREMENTS.—Any coverage provided under paragraph (1) shall be subject to pre-authorization or pre-certification as required by the plan or issuer, and such coverage shall include any surgical treatment which, in the opinion of the treating physician, is medically necessary to approximate a normal appearance.

''(3) TREATMENT DEFINED.—

''(A) IN GENERAL.—In this section, the term 'treatment' includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including—

''(i) procedures that do not materially affect the function of the body part being treated; and

''(ii) procedures for secondary conditions and follow-up treatment.

''(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.''.

(2) CONFORMING AMENDMENT.—Section 2762(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–62(b)(2)) is amended by striking ''section 2751'' and inserting ''sections 2751 and 2754''.

(c) EFFECTIVE DATES.—

(1) GROUP MARKET.—The amendments made by subsection (a) shall apply with respect to group health plans for plan years beginning on or after January 1, 2000.

(2) INDIVIDUAL MARKET.—The amendment made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

(d) COORDINATED REGULATIONS.—Section 104(1) of Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, and chapter 100 of the Internal Revenue Code of 1986''.

AMENDMENT NO. 1249

Strike section 302 of the bill and insert the following:

SEC. 302. PERMISSIBILITY OF CIVIL ACTIONS.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following subsection:

''(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

''(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

''(A) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action under State law to recover damages resulting from personal injury or for wrongful death against any person—

''(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan; or

''(ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

''(B) REQUIREMENTS.—A participant or beneficiary may only commence a civil action under subparagraph (A) if the participant or beneficiary has participated in and completed an external appeal with respect to the decision involved.

''(C) DAMAGES.—In a civil action permitted under subparagraph (B), the participant or beneficiary may only seek compensatory damages.

''(D) LIMITATION ON DAMAGES.—A group health plan shall not be liable for any noneconomic damages in the case of a cause of action brought under subparagraph (A) in excess of $250,000.

''(2) EXCEPTION FOR EMPLOYERS AND MEDICAL PROVIDERS.—

''(A) EMPLOYERS.—

''(i) IN GENERAL.—Subject to clause (ii), paragraph (1) does not authorize—

''(I) any cause of action against an employer maintaining the group health plan or against an employee of such an employer acting within the scope of employment, or

''(II) a right of recovery or indemnity by a person against an employer (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

''(ii) SPECIAL RULE.—Clause (i) shall not preclude any cause of action described in paragraph (1) against an employer (or against an employee of such an employer acting within the scope of employment) if—

''(I) such action is based on the employer's (or employee's) exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(II) the exercise by such employer (or employee of such authority) resulted in personal injury or wrongful death.

''(B) MEDICAL PROVIDERS.—Paragraph (1) does not authorize any cause of action against a health care provider for failure to provide a health care item or service where such provider acted in good faith in relying upon a determination by the group health plan involved to deny such item or service and such denial results in injury or death.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting a cause of action under State law for the failure to provide an item or service which is specifically excluded under the group health plan involved.

''(4) DEFINITION.—In this subsection, the term 'medical provider' means a physician or other health care professional providing health care services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts and omissions occurring on or after the date of the enactment of this Act from which a cause of action arises.

NOTICE OF HEARING

SUBCOMMITTEE ON WATER AND POWER

Mr. SMITH of Oregon. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on Water and Power.

The hearing will take place on Wednesday, July 28, 1999 at 2:30 p.m. in room SD–366 of the Dirksen Senate Office Building in Washington, DC.

The purpose of this hearing is to receive testimony on S. 624, To authorize construction of the Fort Peck Reservation Rural Water System in the State of Montana, and for other purposes; S. 1211, to amend the Colorado River Basin Salinity Control Act to authorize additional measures to carry out the control of salinity upstream of Imperial Dam in a cost-effective manner; S. 1275, to authorize the Secretary of the Interior to produce and sell products and to sell publications relating to the Hoover Dam, and to deposit revenues generated from the sales in to the Colorado River Dam fund; and S. 1236, to extend the deadline under the Federal Power Act for commencement of the construction of the Arrowrock Dam Hydroelectric Project in the State of Idaho.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send two copies of their testimony to the Subcommittee on Water and Power, Committee on Energy and Natural Resources, United States Senate, 364 Dirksen Senate Office Building, Washington, DC, 20510–6150.

For further information, please call Kristin Phillips, Staff Assistant or Colleen Deegan, Counsel, at (202) 224–8115.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. JEFFORDS. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be granted permission to meet